State of Arizona
"Protecting the Public's Health"
Naturopathic Physicians Board of Medical Examiners
1400 W. Washington, Ste 230 ♦ Phoenix, AZ 85007
Telephone: (602) 542-8242 ♦ FAX: (602) 542-3093 ♦ www.npbomex.az.gov

Application to ENGAGE IN A PRECEPTORSHIP TRAINING PROGRAM IN NATUROPATHIC MEDICINE

THIS APPLICATION AND ANY DOCUMENT SUBMITTED WITH THIS APPLICATION BECOMES THE PROPERTY OF THE STATE OF ARIZONA AND IS NOT RETURNED TO THE APPLICANT.

Make a copy of this completed application for your records

The following fees are required with this application

Include a Cashier's Check or Money Order in the amount of $150.00 (This fee is not prorated)
Include a Cashier's Check or money order in the amount of $29.00 payable to DPS
(go to website contact and email us to request a FP Card)
Include your Official Fingerprint Card completed by an authorized technician.
Include one (1) passport-size photograph taken within the last 60 days with your signature on the back.
NOTE: Renewal is no later than the expiration date listed on the certificate. Penalty Fee for late renewal $75.00

~ Fees are not refundable under any Circumstance ~

I understand:

- The filing of this application grants authority to the Board to obtain information from other licensing agencies and boards in the United States or another country; and
- That any falsification in my application to the Board is adequate cause by the Board to deny my application, and the Board, upon notice to me, may hold a hearing to revoke the Certificate to Engage in a Preceptorship Training Program that is issued to me by the Board; and
- That the Board may report any falsification of information to other licensing agencies and boards; and
- That I am required to report changes in status in regards to this application including address and telephone number changes; and
- That I am required to diagnose and treat patients under the supervision of a physician licensed by the State Board; and
- That if this application is approved, I am required by law to promptly renew this certificate no later than the expiration date listed on the certificate.

When the space provided on this application is not sufficient to answer a question, the applicant shall use a separate sheet of paper to identify the question and provide an answer for that question.

If you will engage in preceptorship training at a location other than the Preceptorship Training Program's facility address listed in this application please list the other sites on a separate sheet of paper:
There will be an applicable fee of $20.00 for each additional location.
This application may be amended at a later date by notifying the Board of the address of the additional site.

I, _____, hereby make application to the State of Arizona Naturopathic physicians Board of Medical Examiners to be approved by the Board to engage in a preceptorship training program in naturopathic medicine under the supervision of a physician licensed in accordance with Arizona Revised Statutes, Title 32, Seq.,

Legal Name: _____
Last **First** **Middle**

Clinic Address: _____

City: _____, **State:** _____ **Zip:** _____ **Phone #:** _____

Residential Address: _____

City: _____, **State:** _____ **Zip:** _____ **Home Phone#**_____

Email Address:_____

Date of Birth: _____/_____/_____ **Social Security Number** _____/_____/_____ **Gender: [ ] Female [ ] Male**

Height: _____ **inches ♦ Weight:** _____ **pounds ♦ Hair Color:** _____ **♦ Eye Color:** _____

School Information:

Name of Medical School from which you graduated: _____

Address: _____
Number & Street **City** **State** **Zip**

☐ **Yes, I have requested my transcript with graduation date to be sent to NPBOMEX**

Preceptorship Training Program Information:

Program Name: _____

Facility Address: _____
Number & Street City State Zip

Facility Phone Number:_____

Date Preceptorship Training Program Begins: _____/_____/_____

Anticipated Date of Completion of Preceptorship Training: _____/_____/_____

Supervising Physician Information ;

_____
Physician Name **State of Arizona Physician's License Number**

_____
Number & Street **City** **State** **Zip**

< Alternative Format of Submitting Application >

An individual with a disability who, as a result of that disability, requires this application in an alternative format may contact the Board's Americans with Disability coordinator at (602) 542-3095.

Answer the Following Questions

A. Have you ever been charged with, arrested, convicted of, or entered into a plea of no contest to a felony or a misdemeanor? [ ] Yes [ ] No

B. Have you ever had a license/certificate, including a driver's license, suspended or revoked by any agency? [ ] Yes [ ] No

C. Have you ever been disciplined by any agency for any act of unprofessional conduct as defined in Arizona Revised Statutes, Section 32-1501? [ ] Yes [ ] No

D. In lieu of disciplinary action by an agency, have you ever entered a consent agreement or stipulation with a licensing agency? [ ] Yes [ ] No

E. Do you have a complaint pending before any agency? [ ] Yes [ ] No

F. Have you ever been found guilty of being medically incompetent? [ ] Yes [ ] No

G. Have you ever been a defendant in any malpractice matter that resulted in a settlement or judgment? [ ] Yes [ ] No

H. Do you have any medical condition that in any way impairs or limits your ability to practice medicine? [ ] Yes [ ] No

An applicant is required to submit a written supplement to this application if the answer is Yes to any of the above questions. ** The Fact that a conviction and/or criminal offense has been pardoned, expunged or dismissed, or that your civil rights have been restored does not mean that you can answer "No" to questions A through I.

I have READ and UNDERSTAND: 32-1561 and R4-18-108

Subscribed And Sworn To Before A Notary Public:

State of_____)

County of_____)

Print The Applicant's Full Name: _____ being first duly sworn upon his or her oath deposes and says all of the following: I am the person named in this application. I have read and understand the contents of this application. The information contained in this application is true and correct to the best of my ability and the information submitted is without fraud, deceit or misrepresentation. I hereby authorize any hospital, institution, organization, personal physician, past or present employer, past or present business or professional associate or any local, state, federal or foreign governmental agency to release any information to the State of Arizona in connection with my application and state that a photocopy of this authorization shall have the same effect as the original. I also authorize the State of Arizona Naturopathic Physicians Board of Medical Examiners, or its successor, to release any information submitted by me, upon request, to the public or to any licensing agency, or to any other person, when such request is required or permitted by Arizona Revised Statutes. I acknowledge that any falsification in my application is cause to deny my application or for the Naturopathic Physicians Board of Medical Examiners to hold a hearing to revoke any naturopathic medical student internship, preceptorship or preceptorship training registration that is issued to me by the Board. I authorize the Board to tape record any application interview that is conducted of myself in regards to this application.

Signature of Applicant: _____

Subscribed and sworn to before me this _____ day of _____, 200_____

Notary Public Signature _____

My Notary Commission expires _____

Notice To Applicant:

It is your responsibility to have your supervising physician of the Preceptorship Training Program verify that said physician will supervise you in the diagnosis and treatment of patients. The physician is required to be licensed by the Naturopathic Physician's Board of Medical Examiners.

I submitted an application to the State of Arizona Naturopathic Physicians Board of Medical Examiners for approval to engage in a Preceptorship Training Program. I have informed the Board that you are the Supervising Physician of the Preceptorship training program. I request and authorize you to send directly to the State of Arizona Naturopathic Physicians Board of Medical Examiners the information requested.

Print Name_____

Applicant Signature: _____

SUPERVISING PHYSICIAN'S VERIFICATION FORM
TO ALLOW A NATUROPATHIC MEDICAL STUDENT INTO A
PRECEPTORSHIP TRAINING PROGRAM IN NATUROPATHIC MEDICINE

SUPERVISING PHYSICIAN'S Information

Name: _____/_____
Print Name Arizona Medical License #

Address: _____
Number & Street City State Zip Code

Information Below To Be Completed By Supervising Physician

Verification of SUPERVISING PHSYICIAN

A. Will the applicant listed above be supervised by you in the diagnosis and treatment of patients? [ ] YES [ ] NO

B. Date the applicant will begin training: _____/_____/_____

C. Anticipated date the applicant will conclude training: _____/_____/_____

D. I hereby verify under oath that I, _____, Arizona physician's license number_____, am licensed as a physician by the State of Arizona and that I will supervise the naturopathic medical student applicant named herein in the diagnosis and treatment of patients.

E. In the event that I withdraw from supervising the applicant named above, I will immediately notify the Board.

F. In those events when I am not available, the following Licensed Physician will be my designated supervising physician agent for the applicant named above:

Supervising Physician's Designated agent: _____

Designated Agent's Arizona Physician's License Number: _____

Address of Designated Agent: _____

City, State, Zip: _____

Signature of Supervising Physician: _____Date_____

READ THE FOLLOWING
KEEP THIS INORMATION FOR *YOUR* RECORDS

32-1561. Internship, clinical fellowship and **preceptorship** programs; duties; prohibitions

A. A person who is a graduate of an approved school with a degree of doctor of naturopathic medicine and who wishes to engage in an internship program, a clinical fellowship or a **preceptorship** program shall submit an application for certification as prescribed in section 32-1524.

B. If the application submitted pursuant to subsection A of this section is approved by the board, that person may engage in a board approved internship program, clinical fellowship or **preceptorship** program under the **direct supervision** (***Is physically present and within sight or sound of the person supervised and is available for consultation regarding procedures that the physician has authorized and for which the physician remains responsible.***) of a physician licensed under this chapter or by a physician licensed pursuant to chapter 13, 17 or 29 of this title.

C. The board by rule may prescribe naturopathic medical treatment procedures that a person who is certified under this section may perform under the **direct supervision** (***Is physically present and within sight or sound of the person supervised and is available for consultation regarding procedures that the physician has authorized and for which the physician remains responsible.***) of a physician licensed under this chapter if the board determines that these procedures:1. May be competently performed by the graduate.2. Do not exceed the procedures that the supervising physician has been licensed by this state to perform.D. A person who is certified under this section may do clerical tasks without direct supervision if the tasks do not involve diagnosing or treating a patient's condition.E. If the supervising physician of a person who is certified under this section withdraws from direct supervision, the certificate to engage in the training program held by that person is automatically canceled.F. A person who is certified under this section shall not employ that person's supervising physician and shall not have any financial interest in any business owned by that person's supervising physician.

Furthermore I have **READ** and **UNDERSTAND R4-18-108** regarding the use of title
An UNLICENSED graduate of a Board approved school of Naturopathic Medicine who is certified by the Board to engage in preceptorship training SHALL use the designation "(**PRECEPTEE**)"***after*** any of the following designations, Doctor of Naturopathic Medicine, N.M.D., Doctor of Naturopathy, N.D. Naturopath, Naturopathic Physician, or Naturopathic Medical Doctor .
The PRECEPTEE SHALL also ensure that any patient treated by the preceptee **SIGNS AN INFORMED CONSENT TREATMENT FORM STATING CLEARLY THAT THE PRECEPTEE IS UNDERGOING TRAINING, IS NOT LICENSED, AND INDENTIFYING THE NAME OF THE SUPERVISING PHYSICIAN.**

THE PRECEPTEE MUST NOT IN ANY WAY LEAD THE PUBLIC TO BELIEVE THAT HE OR SHE IS A LICENSED NATUROPATHIC PHYSICIAN.